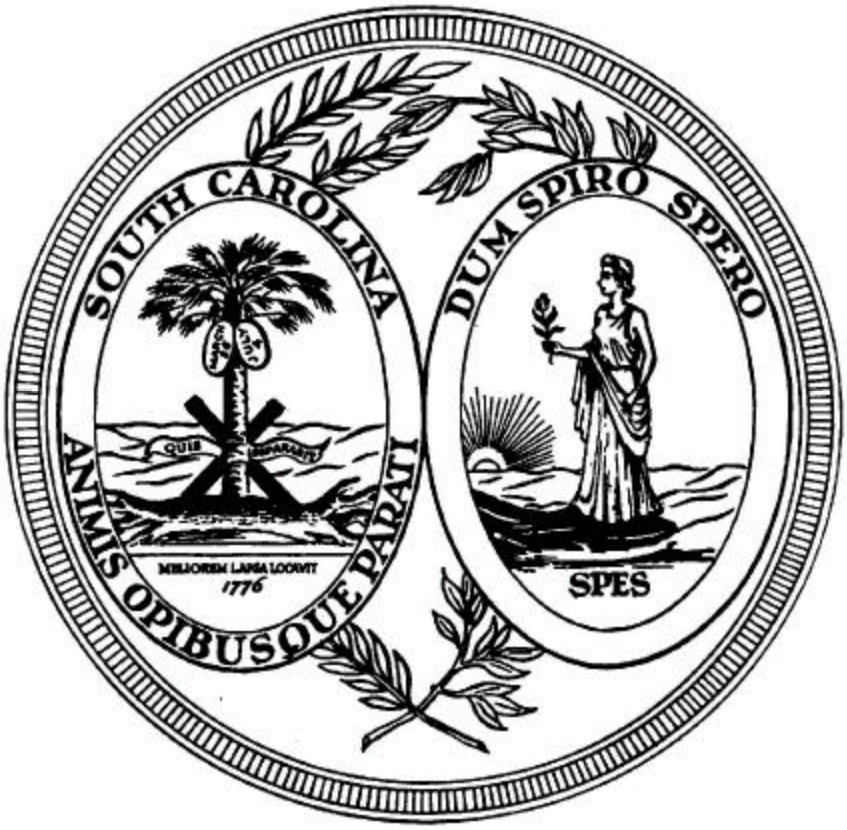
Task Force on Healthcare



Report
February 19, 2003

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Executive Summary

Healthcare is an integral part of improving education and economic development in our state. Healthy children go to school and learn. Likewise, healthy adults go to work and earn. Presently there is a healthcare crisis in America, and our state has not been spared from the effects of this challenging time. Record deficits in our state budget and skyrocketing medical liability insurance costs put many vulnerable citizens at risk for losing healthcare. We must reform Medicaid and healthcare delivery systems to control spiraling cost, while at the same time improving the quality and access to healthcare in our state. To achieve this goal we should:

I. Promote individual responsibility for health and wellness.
At present there are too few incentives within our healthcare delivery system to encourage healthy behavior. The Governor should take a leadership role in promoting health.

II. Reform the current healthcare delivery system to promote preventive care and the cost-effective treatment of illness.
This is especially important for our most needy citizens served by our state's Medicaid system.

III. Organize our healthcare delivery system to increase efficiency and reward desired outcomes.
Presently Medicaid and other healthcare programs are dispersed through various state agencies leading to less accountability and more administrative burden. The system must work in the best interest of the citizens served and the taxpayers of South Carolina.

IV. Enact legislation to address medical liability.
We must fix the medical liability system in order to improve healthcare quality, lower medical costs and avert an impending crisis in access to needed services.

V. Encourage diversity and address disparities in healthcare.
The increasing diversity of our population is not reflected in the healthcare workforce, contributing to outcome disparities among minority populations. Steep budget cuts in mental health have led to a statewide delivery crisis.

VI. Ensure access to healthcare for all South Carolinians.
We must develop more public-private partnerships to provide an alternative healthcare delivery system for the increasing number of South Carolinians who are not eligible for Medicaid and cannot afford health insurance. The state must also ensure access to critical services – including trauma care.

VII. Provide dedicated sources of funding for Medicaid.
All of the important reform efforts we have cited above are dependent on reliable funding for our Medicaid program. It is important to realize that the Federal government matches 3 dollars for every dollar we allocate to our state's Medicaid program. We must find a way to protect Medicaid because it makes sense for our people and our economy.

The following report represents our reasons for identifying these most important issues in South Carolina healthcare and outlines in more detail the steps needed to reform a delivery system in crisis.

I. Promote individual responsibility for health and wellness.

At present there are few incentives within our healthcare delivery system to encourage healthy behavior. The loss of years of productive life, due to preventable behaviors, drains our society of much needed resources and incurs health care costs that could be more productively invested. The Governor should take a leadership role in promoting healthy behaviors.

RECOMMENDATIONS:
1. Implement a statewide campaign to promote wellness – proper nutrition and regular exercise – while discouraging unhealthy behavior – particularly tobacco, alcohol abuse and illicit drug use.
2. Utilize school nurses in preschool programs and local school systems to teach healthy lifestyles – particularly to impact the growing epidemic of childhood obesity. Re-institute physical education at all grade levels.
3. Pursue financial disincentives for unhealthy behavior, which drives up the cost of healthcare for all citizens. As an example – increase the tax on cigarettes and promote primary enforcement of the seat belt law.
4. Strengthen local and state policy around health and wellness and develop a comprehensive public education effort to deliver the health message utilizing all resources in our state.
5. Utilize the faith-based community to deliver the health message.
6. Identify and implement proven programs which foster healthy behavior – such as corporate and school fitness testing.

II. Reform the current healthcare delivery system to promote preventive care and the cost-effective treatment of illness.

A key component of health reform in South Carolina is to promote preventive care and cost effective treatment. This is particularly important for our most needy citizens served by our state's Medicaid system. To accomplish this we must have sufficient physician participation in our Medicaid program to allow enrolled recipients to find a doctor who knows and cares for them. Many would refer to this as a "medical home." The state must provide appropriate resources and authority to physicians to manage patient care.

South Carolina must invest in preventive care. For example, while the South Carolina immunization rate for children under the age of two remains above the national average, the trend for the past three years shows a decline. Renewed efforts to promote immunization are critical to prevent costly communicable diseases among children and adolescents. The 2000 rate for SC was 87.1% compared to a national average of 77%.

The citizens of South Carolina need highly trained physicians to provide primary and specialty medical care. To assure access to physicians for low-income South Carolinians, the way physicians are compensated must change. There are specific factors that have been shown to influence the willingness of physicians to accept Medicaid patients. These factors involve amount of payment for services, method of payment and the administrative costs of participation in the system.[1] There are significant benefits to our delivery system when patients have a medical home. Chief among these benefits is a decrease in the use of emergency services among Medicaid patients, increase in compliance with therapy and appropriate referral for specialty services.[2,3]

South Carolina has just begun to embrace medical home initiatives beyond the traditional fee for service system. Since 1996 the Medically Fragile Children's Program, serving the greater Columbia area, has provided a fully array of medical services to children in foster care. Frequently foster parents became exhausted from taking their children to four and five different location each week for therapy and medical treatments. Most children had little primary medical care resulting in frequent hospitalizations and emergency room visits. This medical home program saved Medicaid approximately one million dollars on 56 foster children in one year. This all-inclusive health care system for medically complex children has

demonstrated better utilization of health care services, improved child and family outcomes and significantly reduced costs to SC Medicaid. Similar Medical Home innovations must be prioritized to meet South Carolina's health goals.[4]

South Carolina remains significantly short of primary care physicians and many specialty physicians. With an increasing need for physicians as our population grows and with a natural desire to draw quality physicians to our state, we must look at how much we pay for Medicaid services relative to surrounding states.

While paying more for physician outpatient services, North Carolina has realized overall cost savings in the Medicaid program. South Carolina has applied a similar strategy to obstetrical care. From 1985 to 1989, rates for prenatal care and delivery of children were increased from a $450 global fee to $700 for a vaginal delivery and $20 per ante-partum care visit. This resulted in more OB providers in the system, decreased the number of women in South Carolina receiving less than adequate prenatal care, and improved the number of women receiving prenatal care in the first trimester of pregnancy.[5]

Thus cutting payments to providers would likely result in further decreasing the number of participating physicians causing more patients to seek care in an emergency room setting and driving Medicaid costs higher. South Carolina has already begun to see this trend. For example, in the Midlands, ER patient load increased by nearly 25 percent from 1992 to 1999, according to the State Budget and Control Board's research office.[6] It is important to note that we cannot limit care under current practice conditions. This means South Carolina is already paying for all rendered services.

Instead of shifting the costs to the insured and the providing institutions and physicians, we need to seek a strategy of directing beneficiaries to the point of care where they will receive high quality care at a lower cost to the Medicaid system. This has benefits in both cost reduction and improvement of patient care and health.[7] One way to do this is to bring South Carolina's physician reimbursement for outpatient billing codes and inpatient/outpatient procedures to 100% of the Southeast average and institute tax deductibility of unreimbursed care.

South Carolina Medicaid should undertake development of an electronic system to follow patient outcomes and management practices for quality

improvement purposes. This system could reward positive clinical results and outcomes desired by all of South Carolinians. Eliminating waste and clinical duplication in Medicaid may assist in funding for providers.

Information is necessary to a better understanding of the health of South Carolinians and what is successful (or not successful) in improving their health. Although not widely recognized, the SC Office of Research and Statistics (ORS) has built one of the country's leading state data bases for health care-related data. If South Carolina is to be successful in determining what services and therapies provide the best health outcomes, then the success of ORS's Health and Demographics Division is crucial. A relatively small investment in this office may produce significant results in savings as well as improving health outcomes.

Recommendations:

1. Place a priority on effective medical homes to meet South Carolina's health goals. Effectiveness would be determined by measuring outcomes and cost data.
2. Increase provider reimbursement to 100% of the Southeast average for Medicaid payments.
3. Review any Medicaid payments to any provider or entity that exceed 150% of the Southeast average for Medicaid payments.
4. Make un-reimbursed care tax deductible to maximally offset cost shifting by all participants in the healthcare system.
5. Develop an electronic system to follow health outcomes and management practices to improve quality of outcomes.
6. Develop an electronic medical record system to facilitate the development of a quality improvement initiative.

III. Organize our healthcare delivery system to increase efficiency and reward desired outcomes.

Presently Medicaid and other healthcare programs are dispersed through various state agencies leading to less accountability and more administrative burden. The system must work in the best interest of both the citizens served and the taxpayers of South Carolina. We must strive for a system that allocates resources to critical services based on their true costs and the desire of society to pay for them. Our conclusions support the Governor's Task Force on Government Restructuring and Campaign Finance Reform and the Legislative Audit Council's Review of Non-Medicaid Issues.[8,9]

Recommendations:

1. Restructure South Carolina's health and human service agencies to consolidate the current fragmented structure, reduce duplicative and similar services provided by multiple agencies, increase accountability, and improve the efficiency and effectiveness of services.

2. Include all eight health and human service agencies in the Cabinet to provide the Governor the authority to ensure cost effective service delivery and administration. Agencies currently not in the Cabinet are DHEC, DDSN, DMH, Vocational Rehabilitation, and the Commission for the Blind. Current Cabinet agencies are DHHS, DSS, and DAODAS.

3. Restructure the eight agencies to have one person in charge, combine administrative functions, and consolidate programs serving the same client populations. Client services that should be combined include: mental health and addiction services; services provided to senior citizens both within the aging network and in multiple agencies; rehabilitative services; and children with disabilities. Consolidation would provide clients a central point of entry to receive services, and the existing administrative costs and costs associated with referrals between state agencies would be reduced.

4. Most health and human service agencies provide services throughout the state in local sites. Co-location of services at the local level should be addressed to provide easier client access and to reduce administrative overhead.

5. Develop a single information system to consolidate all state agency data. Critical to any system of accountability is the ability to generate and collect reliable, meaningful data. Under the current fragmented system, the state does not have accurate data about who is served, how they are served, what it costs to serve, or billing and collection information. Client billing and collections are weak and can be increased easing the burden on taxpayers. Medicaid eligibility determinations should be more efficient and thereby provide better service to clients and reduce costs.

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6. Perform a cost effectiveness analysis of all Medicaid Optional Benefit services. Determine continuation of optional programs based on evaluation of the cost of providing the services in relation to the health outcomes produced.

7. Review pharmaceutical costs in the context of other Medicaid services. Review the proposed Preferred Drug List (PDL), and take advantage of established prices in other Medicaid markets as cost containment initiatives. If other states are negotiating lower net prices for pharmaceuticals than South Carolina currently receives, then South Carolina should pursue arrangements similar to those in other states, provided that quality of medical care is maintained.

8. Target resources on programs that produce desired health behaviors and prevent unnecessary healthcare costs including further expansion of services to children under SCHIP program to at least 200% of FPL. Promotion of healthy behaviors and increased preventive care will reduce the burden of disease and produce cost savings for taxpayers.

   For example every dollar spent for tobacco-use prevention in schools translates into $16 dollars in reduced future healthcare costs. The SC Youth Risk Behavior Survey for 2001 shows a youth smoking rate of 27.6%. A 1% reduction in adult smoking in SC could reduce healthcare costs $9 million. 20 cents of every dollar spent on healthcare is directly related to tobacco use.

9. Maximize the use of private sources for healthcare delivery to foster competition – lowering costs and improving quality. Review direct healthcare services provided by state agencies to identify any service better provided by the private sector. Compare the costs of state agency delivered healthcare services to costs of increased provider reimbursement that would encourage providers to assume provision of healthcare services.

10. Encourage collaboration and coordination of public institutions of higher education on research grants and initiatives that address healthcare. Frequently grants involve several institutions, or programs with limited coordination of effort.

11. Review efforts to reduce fraud and abuse particularly in disability and workers compensation claims.

IV. Improve Quality and Lower Costs through Reform of the Medical Liability System.

The system for adjudicating medical liability in our state is badly in need of repair. Our current system is causing degradation in the quality of medical care while simultaneously causing a dramatic increase in the cost of care. A recent report by the U.S. Department of Health and Human Services identifies South Carolina as one of the "New States in Crisis" with regard to medical liability. Dramatic increases in malpractice premiums are related to the fact that reasonable limits on non-economic damages have not been implemented.[10] Settlement and judgments paid out by the South Carolina JUA and PCF have increased 367% in the past five years, resulting in skyrocketing premiums.[11] This comes at a time when physician reimbursement rates and collections are steadily declining and all other overhead expenses are increasing, making it difficult to recruit and retain physicians in our state.[12]

Tragically the effect of the current malpractice system is to harm the very people it is designed to protect. The malpractice system does not accurately identify negligence, deter bad conduct, or provide justice.[13] Costs are further elevated by defensive medicine in the form of potentially unnecessary tests and procedures while exposing the patient to additional risks. The reporting of medical errors essential to quality improvement is stifled. Physicians are limiting their practices to avoid high-risk patients and procedures, making it more difficult for South Carolinians to obtain the care they need.

The impact on seniors is even more profound. Nursing homes have become the new target of the litigation system. The average cost per year nationwide of insuring an occupied skilled nursing bed has increased from $240 in 1996 to $2360 in 2001, and the rate of increase in South Carolina is reported to be even greater. Since the majority of these costs are borne by the tax-paying public, resources are being consumed that could be used to expand health coverage to the poor and prescription benefits to the elderly. In addition state run liability insurance coverage (SC Joint Underwriting Association) is not available to long term care providers. The decreasing number of private liability insurers has caused higher insurance premiums for less coverage. Nursing home reimbursement rates and annual cost reports are unable to reflect the unpredictable cost of liability coverage.

Only 28% of every malpractice premium dollar actually goes to patients with 57% going directly to attorneys and the remainder going to administrative and related costs. Surely there is a better way to spend this money. Since the majority of the physicians in this state are insured by the not-for-profit JUA and PCF, the argument that liability reform bolsters insurance company profits holds no water in South Carolina. Furthermore, another U.S. Department of Health and Human Services report points out that:

> "Interest groups supported by trial lawyers argue that the recent crisis in the medical litigation system is only a reflection of an "insurance cycle": they claim that the management practices of the insurance industry have caused the crisis. But their claims are not supported by the facts. Comparisons of states with and without meaningful medical liability reforms provide clear evidence that the broken litigation system is responsible."[14]

The Pittsburgh Post-Gazette reported that in 1998 the city of Philadelphia alone paid out more in Medical Malpractice claims than the entire state of California.[15] This is attributable largely to California's highly successful Medical Injury and Compensation Reform Act of 1975 ("MICRA").

While placing a cap on non-economic damages is a vital ingredient to the success of any type of medical liability reform, it is simply not enough. The current tort system provides little or no justice in the majority of cases in terms of compensating those injured by a physician's negligence. Rather the current system encourages the filing of frivolous lawsuits against a physician regardless of the issue of negligence to facilitate a settlement. Specifically, Only 1.2% to 1.9% of jury trials result in a verdict for the plaintiff. Further only 1.53% of persons who are injured by medical negligence file a claim. Thus, the current system is inadequate in terms of a remedy and redress for both the plaintiff and the non-negligent physician.

The data are clear. The current litigation system is threatening healthcare quality for all South Carolinians as well as raising the cost of healthcare for all South Carolinians. We must become committed to improving healthcare quality by the prompt reporting of medical errors and promptly compensating those who have been truly injured for the actual economic damages they have suffered. We must be equally committed to stopping bad faith medical malpractice lawsuits and capping the subjective, non-economic damages, which are crippling our healthcare system. The success of The

Medical Injury Compensation Reform Act of 1975 ("MICRA") has been well documented. "MICRA" should be refined and built upon. To avert an impending health care crisis, medical liability reform must be addressed.

Recommendations:

1. Pass meaningful tort reform for the healthcare profession that caps non-economic losses to plaintiffs at $250,000 per plaintiff. Awards to multiple plaintiffs in a case cannot exceed $500,000.

2. Limit plaintiffs' attorney fees to a prescribed schedule based on the size of the award.

3. Create special courts or designate special judges to hear medical malpractice claims. These judges would have expertise in malpractice issues and would be better able to toss out frivolous lawsuits. Encourage the special courts to sanction lawyers and award litigation costs in frivolous cases.

4. Develop clear procedures for reducing medical errors in concert with doctors and hospitals around the state.

5. Extend tort immunity to healthcare providers who treat low-income patients under contract with the state.

6. Provide for periodic payments for future loss.

7. Make evidence of healthcare coverage admissible.

8. Replace traditional joint and several liability laws with proportionate liability.

V. Encourage diversity and address disparities in healthcare.

The increasing diversity of our population has not been reflected in the healthcare workforce, contributing to outcome disparities among minority populations.

Many communities are underserved medically even as they grow in number. Health disparities exist between racial and ethnic groups and are also related to rural/urban differences, socio-economic differences, environmental and occupational exposure, and access to healthcare and education. We must promote cultural education to better address the diversity of our state. Disparities in rural and underserved areas require attention as well.

The Department of Mental Health has seen unprecedented budget cuts resulting in many citizens with mental illness landing inappropriately in emergency rooms and jails. Law enforcement authorities may spend hours or days sitting with mentally ill patients as they wait for services. Jails, many hospitals, and primary care practices are not equipped to provide adequate care or treatment for mental illness. The state should consider funding the establishment or expansion of local crisis stabilization programs in each of the seventeen community mental health centers. These programs have the potential to provide better care and reduce cost of institutional care.

The rapidly growing aged population requires special attention. Understanding the risks facing the elderly and taking appropriate actions can help delay or prevent the loss of independent functioning. This has important economic as well as social consequences. Presently approximately 70% of the state's Medicaid dollars are spent treating the aged, disabled and blind. Our strategic goal should be to allow this population to *age in place* and avoid expensive out-of-home and institutional care.

Recommendations:

1. Educate future healthcare providers in rural and underserved communities to reduce disparities in health outcomes.
2. Address the gap in disparate health outcomes between minority and majority populations.
3. Increase the number of minority healthcare professionals.
4. Provide security and improve access to care for the aged, disabled and mentally ill.
5. Implement Legislative Audit Council's recommendation to expand community long term care as per "Options for Medicaid Cost Containment".

VI. Ensure access to healthcare for all South Carolinians.

From 1990 to 1999 there was increase of almost 450,000 SC residents who were uninsured. Since then we have had three straight years of double digit increases in insurance premiums resulting in a further increase in the number of working adults without health insurance. In order for us to reverse this trend we must develop an alternative healthcare delivery system for the working poor to bridge the gap between governmental programs and private

insurance to ensure that all South Carolinians have access to healthcare. We must also be sure that funds are provided and costs allocated in such a way that we protect services vital to the welfare of our society.

By creating a public-private partnership through a Medicaid match supported program we can utilize our knowledge that providing a medical home with primary and preventive healthcare will, in the long run, give us the most cost-effective healthcare system.

Our local emergency departments will remain particularly vulnerable to the growing number of uninsured and yet provide vital service to our communities. Trauma care costs have been and will continue to be a significant portion of state healthcare dollars as the state continues to grow at a rate exceeding the national average. The citizens of South Carolina expect and deserve the best trauma care; however, South Carolina's trauma system is currently in critical condition. This voluntary system is in need of a renewable source of funding as 40-50% of trauma patients are uninsured. Importantly, an organized and functioning trauma system is essential to respond to a natural or terrorist mass casualty. We must assure that funds that are available though insurance and legal settlements make it back to providers and medical facilities.

Recommendations:

1. Increase support for the wide range of non-profit healthcare initiatives serving the uninsured that already exist in South Carolina, including Federally Qualified Health Centers, Crisis Ministries (a shelter providing primary and mental healthcare Charleston County), Commun-I-Care (a statewide program), Tri-county Project Care (Charleston County), Richland Care (Richland County), the Friendship House and S.O.S. Healthcare (Horry County), the MedWell program (Greenville County), and Volunteers in Medicine (Hilton Head Island). Organizations like these help ensure that the medically underserved have at least some measure of adequate medical attention and at the same time save their communities thousands of dollars each month.

2. Utilize Medicaid match funding with a public-private partnership to develop an alternative healthcare delivery system for persons not Medicaid eligible and whose incomes are less than 200% of the Federal Poverty Level (FPL).

3. Encourage small businesses to form insurance pools to provide healthcare coverage for employees.

4. Encourage the expansion of employer based plans to include uncovered family members.

5. Provide Umbrella organizations to coordinate existing resources within each community to educate patients how to access available services and manage chronic disease states.

6. Pursue federal legislative relief from rules and regulations that impede the delivery of healthcare services.

7. Develop a coordinated and simplified eligibility system.

8. Aggressively fund and preserve our state's trauma centers.

9. Promote system changes that encourage provider participation in the state's Medicaid healthcare delivery system.

10. Provide a state income tax credit to physicians who provide unfunded care. An on-call physician who provides emergency or indigent care usually is not reimbursed.

VII. Provide dedicated sources of funding for Medicaid.

All of the important reforms we have cited above are dependent on reliable funding, especially for our Medicaid program. It is important to realize that the Federal government matches almost three (3) dollars for every one (1) dollar the state allocates to the Medicaid program. Under-funding the Medicaid program results in cost shifting to private businesses and other payers of healthcare. Therefore, the state must find a way to protect Medicaid – it makes sense for our people and our economy.

Thus in order to achieve reform, our Medicaid system needs consistent annualized funding. Because tobacco related costs are responsible for 20% of every dollar spent on health care in the US, it is only just that our society places more of the financial burden of these costs on tobacco users. In addition to being more equitable, an increased tax on tobacco products will have the additional benefit of reducing the number of people who choose to

smoke. As stated by the Surgeon General on many occasions - tobacco is the number one preventable cause of death in America. Further, according to a Centers for Disease Control Study released in May 2002, for each pack of cigarettes sold in the US in 1999, $3.45 was spent on medical care related to smoking and $3.73 was spent on productivity losses from smoking. Given the combined healthcare and productivity cost of $7.18 per pack, it is understandable that both the business community which is attempting to provide health coverage for their employees and the healthcare delivery system which is collapsing under the weight of un-reimbursed care are in support of shifting this burden to the tobacco user.

We are aware that increased fees on tobacco products should be considered as part of an overall view of our state's tax policy. We did not address the issue of whether or not these taxes should be shifted from other funding sources or should be new taxes.

Recommendations:

1. Provide consistent funding for Medicaid by either increasing or shifting a substantial part of the tax burden from society as a whole to the users of tobacco products.

2. Consider additional funding sources for trauma care through an increase in fines for DUI and moving vehicle violations.

While some members of the task force may disagree with certain specific points or recommendations, this report represents a consensus of the reform efforts needed in our state's health care delivery system.

We thank you for the opportunity to make the above recommendations and look forward to working together with you for a healthier South Carolina.

The Healthcare Task Force

[1] Berman S. “Factors that influence the willingness of private primary care pediatricians to accept more Medicaid patients” Pediatrics – 01-Aug-2002; 110(2 Pt 1): 239-48
[2] Eisert S., Gabow P. “Effect of Child Health Insurance Plan Enrollment on the Utilization of Health Care Services by Children Using a Public Safety Net System” Peditrics, Volume 110 No 5 November 1999
[3] Berman S. “The Influence of Hanving an Assigned Medicaid Primary Care Physician on Utilization of Otitis Media-related Services” Pediatrics Volume 104 No 5 November 1999
[4] Partnering with State Agencies to Improve Health Care for Special Needs Children. National Association of Children’s Hospitals and Related Institutions, Sept 2002, Seattle, WA
[5] South Carolina Maternal and Child Health Data Book 2001, Technical Report Series 2000-03, January 2001 page 8-9
[6] The State Newspaper, Tuesday June 26,2001, Columbia, SC. “Midlands' ERs see caseloads growing”
[7] Berman S. “The Influence of Hanving an Assigned Medicaid Primary Care Physician on Utilization of Otitis Media-related Services” Pediatrics Volume 104 No 5 November 1999
[8,9]Task Force on Government Restructuring and Campaign Finance Reform January 2003
Legistlative Audit Council Report on Non-Medicaid Issues January 2003
[10] U. S. Department of Health and Human Services, Special Update on Medical Liability Crisis, September 25, 2002
[11] JUA and PCF Judgement and Settlement Data
[12] Graph of Medicare Reimbursement for Selected Procedures 1998-2002
[13] US Department of Health and Human Services, Update on the Medical Litigation Crisis: Improving Health Care Quality By Fixing Our Medical Liability System, July 24, 2002
[14] U. S. Department of Health and Human Services, Update on the Medical Litigation Crisis: Not the Result of the “Insurance Cycle”, September 25, 2002
[15] Medical Malpractice Insurance Premiums Soar, Pittsburgh Post-Gazette, January 21, 2001